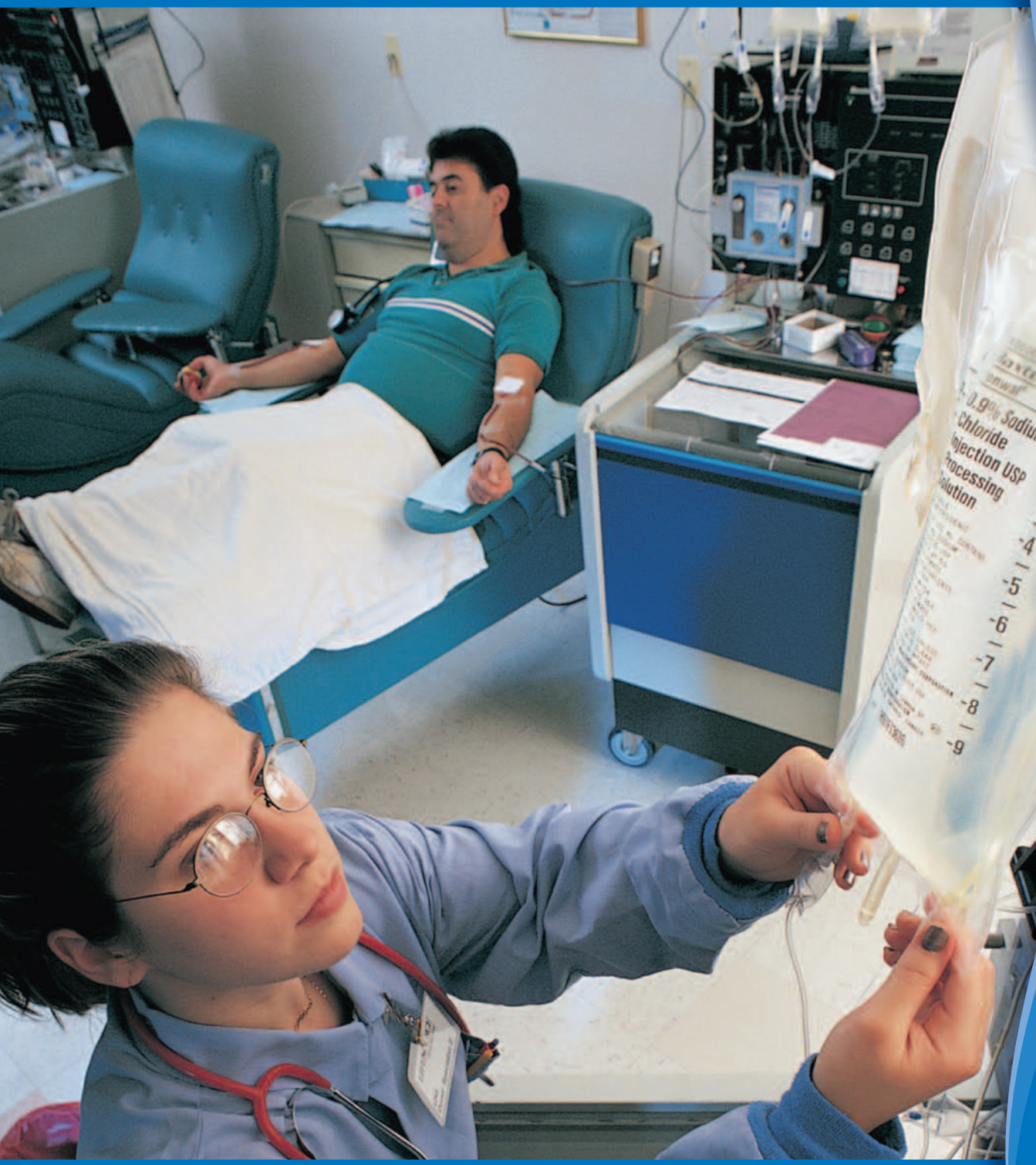
PHYSICIAN'S GUIDE TO

Medicare Coverage of Kidney Dialysis and Kidney Transplant Services



CMS
CENTERS for MEDICARE & MEDICAID SERVICES

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

Medicare Learning Network

Disclaimer

This publication was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services. The Centers for Medicare & Medicaid Services (CMS) employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this guide. This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

Contents

Introduction

If you are a physician who has patients with permanent kidney failure, this booklet is for you. It tells you:

- **How your patients get Medicare if their kidneys fail;**
- **How Medicare helps to pay for kidney dialysis and kidney transplants; and**
- **Where to get help.**

This booklet explains how Medicare helps pay for kidney dialysis and kidney transplant services in the Original Medicare Plan, also known as "fee-for-service." If your patients are in a Medicare Advantage Plan (new name for Medicare + Choice), which includes Medicare Managed Care Plans, Medicare Private Fee-for-Service Plans, and Medicare Preferred Provider Organization Plans, their plan must give them at least the same coverage as the Original Medicare Plan, but it may have different rules. The costs, rights, protections, and/or choices of where your patients get their care may be different if they are in one of these plans, and they may be able to get extra benefits. Encourage your patients to read their plan materials or call their benefits administrator for more information if they have questions.

A similar booklet has been made available to patients. It doesn't include detailed information about kidney failure, dialysis treatments, and kidney transplants. To learn more about these topics, patients should talk not only with you, their doctor, but with their entire health care team—their nurse, social worker, dietician, and dialysis technician. Based on the situation, you and your patient can then select the best treatment options.

The Two Parts of Medicare

Medicare is a health insurance program for people age 65 and older, some people with disabilities under age 65, and most people with End-Stage Renal Disease (permanent kidney failure that requires dialysis or a transplant, sometimes called ESRD).

The two basic parts of Medicare are:

- **Part A (Hospital Insurance)** Most people don't have to pay a monthly payment (premium) for Part A because they (or a spouse) paid Medicare taxes while they were working. Part A helps pay for:
  - o Inpatient hospital care,
  - o Some skilled nursing facility care,
  - o Hospice care, and
  - o Some home health care; and

- **Part B (Medical Insurance)** Part B helps pay for the following covered services and supplies when they are medically necessary:
  - o Doctors' services,
  - o Outpatient hospital care, and
  - o Some other medical services that Part A doesn't cover(like some home health care).

Everyone must pay a monthly premium for Medicare Part B; the Medicare Part B premium for 2005 is $78.20* per month. Premium rates can change yearly and this amount may be higher if a beneficiary does not sign up for Part B when he/she first becomes eligible.

The cost of Part B will go up 10% for each 12-month period during which someone could have had Part B but didn't sign up for it, and there will be a higher premium to pay for as long as that person has Part B. If someone is paying a higher premium because they didn't sign up for Part B when they were first eligible for Medicare, based on age or disability, the higher premium will be removed when they sign up for Part B based on ESRD (see page 5).

Note: Medicare Part B will stop if the monthly premiums are not paid or if the beneficiary decides to cancel it.

Medicare Health Plan Choices

Today's Medicare is about choice, and health plan choices include:

- The Original Medicare Plan (also known as fee-for-service) available nationwide.
- Medicare Advantage Plans (new name for Medicare + Choice) including:
  - o Medicare Managed Care Plans;
  - o Medicare Private Fee-for-Service Plans; and
  - o Medicare Preferred Provider Organization Plans.

A patient may not be able to join a Medicare Advantage Plan if they have End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). People with ESRD who start dialysis and are already in a Medicare Advantage Plan can stay in the plan they are in or join another plan offered by the same company in the same state. Beneficiaries must continue to pay the monthly Part B premium of $78.20* in 2005.

If a patient has had a successful kidney transplant, he or she may be able to join a plan. They can call 1-800-MEDICARE (1-800-633-4227) to find out more about End-Stage Renal Disease and Medicare health plans.

If a patient has ESRD and he/she is in a plan and the plan leaves Medicare or no longer provides coverage in their area, he/she can join another Medicare Advantage Plan if one is available in his/her area. Medicare doesn't pay for everything, and there are some types of insurance that may pay some of the health care costs that Medicare doesn't pay (see pages 29-33).

For more information about Medicare health plan choices, call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy of the Medicare & You handbook. TTY users should call 1-877-486-2048. This handbook is also available at http://www.medicare.gov on the web. Select "Publications."

SECTION 1:

Medicare Basics

Medicare for People with Kidney Failure

Who is Eligible?

Medicare beneficiaries can receive Medicare Part A benefits no matter how old they are if their kidneys no longer work, they need regular dialysis or have had a kidney transplant, and:

- They have worked the required amount of time* under Social Security, the Railroad Retirement Board, or as a government employee; **or**
- They are getting or are eligible for Social Security or Railroad Retirement benefits; **or**
- They are the spouse or dependent child of a person 1) who has worked the required amount of time* under Social Security, the Railroad Retirement Board, or as a government employee or 2) who is getting Social Security, Office of Personnel Management, or Railroad Retirement benefits.

If they get Medicare Part A, they can also choose to enroll in Medicare Part B. *Your patients with kidney failure will need both Part A and Part B for Medicare to cover certain dialysis and kidney transplant services*. If they can't get Medicare, they may be able to get help from their state to pay for dialysis treatments (see page 33).

* Your patients can call the Social Security Administration at 1-800-772-1213 for more information about the required amount of time needed under Social Security to be eligible for Medicare.

How to Sign Up for Medicare

If your patients need Medicare only because of End-Stage Renal Disease (ESRD - permanent kidney failure), they can enroll in Medicare Part A and Part B based on ESRD at their local Social Security office.

If your patients have Part A coverage because of age or disability, but did not take Part B or their Part B coverage was stopped, they can enroll in Part B without paying a higher premium rate if they enroll in Medicare based on ESRD.

The cost of Part B goes up 10% for each 12-month period that someone could have had Part B but did not sign up for it. To avoid paying a higher Part B premium, patients should enroll in Medicare Part B when they apply for Medicare Part A based on ESRD. They should call or visit their local Social Security office of call Social Security at 1-800-772-1213 to make an appointment to enroll in Medicare based on ESRD.

If patients are paying higher Part B premiums because they did not enroll in Part B when first eligible for Medicare based on age or disability, the premium will be reduced to the base rate when they are entitled to Medicare based on ESRD. To stop paying the higher premium rate, patients must enroll in Medicare based on ESRD.

The 2005 Part B premium is $78.20 per month and the new Part B premium amount for 2006 will be available by January 1, 2006.

In all of these situations, patients can call or visit their local Social Security office or call Social Security at 1-800-772-1213 to make an appointment to enroll in Medicare based on ESRD.

Paying for Medicare Part B

When individuals sign up for Part B, the premiums are usually taken out of their monthly Social Security, Railroad Retirement, or Office of Personnel Management payment. If they don't receive any of these payments, Medicare sends them a bill for their Part B premium every three months, and they should get their Medicare premium bill by the 10th of the month. If they don't get their bill by the 10th, they can call the Social Security Administration at 1-800-772-1213.

Patients must pay their Medicare Part B premiums. If they don't pay their Part B premium, or if they choose to cancel it, their Medicare Part B coverage will end.

When Medicare Coverage Begins

When patients first enroll in Medicare based on ESRD (permanent kidney failure) and they are on dialysis, their Medicare coverage usually starts the fourth month of dialysis treatments. For example, if they start getting dialysis treatments in July, their Medicare coverage would start on October 1.

If they are covered by an employer group health plan, their Medicare coverage will still start the fourth month of dialysis treatments. Their employer group health plan will pay first on their health care bills, and Medicare will pay second for a 30-month coordination period. (See page 31)

If patients don't have employer group health plan coverage, there are other types of insurance and programs that may help to pay some of their health care costs.

Important: Medicare will not cover surgery or other services that are needed to prepare for dialysis (such as surgery for a blood access) if they are performed before Medicare coverage begins.

Getting Medicare Coverage Sooner

There are four possible ways to get Medicare coverage sooner:

First, Medicare coverage can start as early as the first month of dialysis if:

- Your patients take part in a home dialysis training program in a Medicare-approved training facility to teach them how to give themselves dialysis treatments at home;
- They begin home dialysis training before the fourth month of dialysis; and
- They expect to finish home dialysis training and give themselves dialysis treatments.

Your patients should talk to you about their dialysis treatment options.

Second, Medicare coverage can start the month your patients are admitted to a Medicare-approved hospital for a kidney transplant, or for health care services that they need before their transplant if their transplant takes place in that same month or within the two following months.

Third, Medicare coverage can start two months before the month of your patients' transplants if their transplants are delayed more than two months after they are admitted to the hospital for the transplant or for health care services they need before their transplant.

Example: A patient was admitted to the hospital on May 25th for some tests she needed before her kidney transplant. She was supposed to get her transplant on June 15th. However, her transplant was delayed until September 15th. Therefore, her Medicare coverage will start in July, two months before the month of her transplant.

Fourth, Medicare coverage starts the first month of dialysis if your patient had a prior period of Medicare based on ESRD.

When Medicare Coverage Ends

If your patients have Medicare only because of kidney failure, Medicare coverage will end:

- Twelve (12) months after the month they stop dialysis treatments; or
- Thirty-six (36) months after the month they had a successful kidney transplant

Your patients' Medicare coverage will *not* end if:

- They have to start dialysis again or get a kidney transplant within 12 months after the month they stopped getting dialysis; or
- They start dialysis or get another kidney transplant within 36 months after a transplant.

Important: For Medicare to pay for kidney dialysis and some transplant services, your patients need both Medicare Part A and Part B. If they don't pay their Medicare Part B premium or if they choose to cancel it, their Medicare Part B will end.

Medicare Preventive Benefits

The preventive benefits of Medicare are extensive and include the following screening tests, examinations, and services: Bone Mass Measurements, Colorectal Cancer Screening, Diabetes Services, Mammogram Screening, Pap Smear and Pelvic Examination, Prostate Cancer Screening, and Shots and Vaccinations.

The following table provides specifics regarding the preventive services, who is covered, and what the patient pays in the *Original Medicare Plan.*

Preventive Services	Who is covered	What the patient pays in the *Original Medicare* Plan
Bone Mass Measurements: Varies with the patient's health status.	Certain people with Medicare who are at risk for losing bone mass.	20% of the Medicare-approved amount (or a co-payment amount) after the yearly Part B deductible.
Colorectal Cancer Screening: • **Fecal Occult Blood Test** - Once every 12 months. • **Flexible Sigmoidoscopy*** - Once every 48 months. • **Colonoscopy*** - Once every 24 months the patient is at high risk for colon cancer. If not at high risk for colon cancer, once every 10 years, but not within 48 months of a screening flexible sigmoidoscopy. • **Barium Enema** - Doctor can use this instead of a flexible sigmoidoscopy or colonoscopy.	All people with Medicare age 50 and older. However, there is no age limit for having a colonoscopy.	Nothing for the fecal occult blood test. For all other tests, 20% of the Medicare-approved amount after the yearly Part B deductible. For flexible sigmoidoscopy or colonoscopy, the patient pays 25% of the Medicare-approved amount if the test is performed in an ambulatory surgical center or hospital outpatient department.
Diabetes Services: • Coverage for glucose monitors, test strips, and lancets. • Diabetes self-management training.	All people with Medicare who have diabetes (insulin users and non-users). If requested by the patient's doctor or other provider and the patient is at risk for complications from diabetes.	20% of the Medicare-approved amount after the yearly Part B deductible. 20% of the Medicare-approved amount after the yearly Part B deductible.
Mammogram Screening: Once every 12 months. (Also, one baseline mammogram between ages 35 and 39.) Medicare also covers new digital technologies for mammogram screenings.	All women with Medicare age 40 and older.	20% of the Medicare-approved amount with no Part B deductible.

Preventive Services	Who is covered	What the patient pays in the *Original Medicare* Plan
Pap Smear and Pelvic Examination: (Includes a clinical breast exam) Once every 24 months. Once every 12 months if the patient is at high risk for cervical or vaginal cancer, or is of childbearing age and has had an abnormal Pap smear in the past 36 months.	All women with Medicare.	Nothing for the Pap lab test. For Pap test collection and pelvic and breast exams, 20% of the Medicare approved amount (or a co-payment amount) with no Part B deductible.
Prostate Cancer Screening: • Digital Rectal Examination - Once every 12 months. • Prostate Specific Antigen (PSA) Test - Once every 12 months.	All men with Medicare age 50 and older.	Generally, 20% of the Medicare approved amount for the digital rectal exam after the yearly Part B deductible. No coinsurance and no Part B deductible for the PSA Test.
Shots (vaccinations): • Flu Shot - Once a year in the fall or winter. • Pneumococcal Pneumonia Shot - One shot may be all that is ever needed. Patients should consult their doctor. • Hepatitis B Shot – If the patient is at medium to high risk for hepatitis.	• All people with Medicare. • All people with Medicare • Certain people with Medicare at medium to high risk for Hepatitis B.	Nothing for flu and pneumococcal pneumonia shots if the health care provider accepts assignment. For Hepatitis B shots, 20% of the Medicare-approved amount (or a co-payment amount) after the yearly Part B deductible.
Welcome to Medicare Physical Examination: One time only, within the first six months the patient has Medicare Part B. Includes measurement of height, weight, and blood pressure, an EKG, education and counseling.	People whose Part B coverage began on or after January 1, 2005.	20% of the Medicare-approved amount after the yearly Part B deductible.

SECTION 2:

Medicare Legislation

How the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) Impacts People with Kidney Failure

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)[1] will allow more Medicare beneficiaries access to prescription drug coverage and reduce the prices they pay for those drugs. This new benefit provides more generous coverage for those individuals with limited means and low incomes. Additionally, a prescription drug discount card will be available for almost all beneficiaries until the full benefit is available nationwide. The Act also includes:

- Provisions for savings for many state governments;
- Better coordination of services for the most needy; and
- Modernization of the drug delivery infrastructure.

New Benefits for Medicare Beneficiaries

The recently enacted prescription drug benefit will help Medicare beneficiaries in several ways:

- The benefit provides access to discounted prescription drugs. Under the fully implemented benefit, those who now pay full retail prices could see their prescription drug prices reduced by an estimated 20 percent or more.[2] In addition, their overall out-of-pocket drug spending could fall by about 50 percent or more in exchange for a premium of about $37 per month in 2006.
- It provides catastrophic protection for all seniors and others with disabilities who have high out-of-pocket prescription drug expenses. A $2, $5, or five-percent coinsurance amount per prescription will be required once a beneficiary accumulates $3,600 in out-of-pocket prescription drug spending.
- It provides additional coverage for millions of Medicare beneficiaries of limited means and with incomes below 150 percent of the federal poverty level. Those of limited means and with incomes below 135 percent of poverty will pay no monthly

premium, no deductible, and only $1 to $5 per prescription in cost-sharing. Those of limited means and with incomes between 135 percent and 150 percent of poverty, will pay reduced premiums, a significantly reduced deductible of $50, and reduced cost-sharing.[3]
- It provides a prescription drug discount card program and immediate assistance of $600 for those individuals with limited savings and low incomes who do not have other coverage.
- It provides savings for states and better coordination of care for Medicare beneficiaries who also qualify for Medicaid.

New Protection for Individuals with High Drug Costs

The new benefit also includes catastrophic protection for seniors with high out-of-pocket drug expenses. Once an individual's out-of-pocket spending reaches $3,600, he/she is responsible for only paying the greater of $2 for a generic or preferred brand-name drug, $5 for a non-preferred brand-name drug, or a 5% coinsurance on any one prescription. This approach focuses government help on reducing the out-of-pocket costs for Medicare beneficiaries who otherwise stand to spend large amounts of money and potentially high percentages of their incomes on prescription drugs.

The new benefit also establishes a range of options for beneficiaries so they can select the drug plan that provides standard drug coverage or alternatives that may better meet their needs.

- To keep premiums lower for Medicare beneficiaries—regardless of age, health status, or income—the new benefit provides seniors a subsidy to purchase needed prescription drugs. This could assist beneficiaries by both lowering their out-of-pocket costs and preventing the kind of "adverse selection" problems that have made drug coverage difficult for many to obtain.
- It also provides reinsurance subsidies for drug plan sponsors so that they are not penalized for attracting less healthy enrollees. The Act provides a reinsurance subsidy of 80% for each beneficiary who is enrolled in a plan and has drug spending above the catastrophic limit. In all cases, however, plans will face appropriate incentives to manage the benefit efficiently and to get the best value for their enrollees and the Medicare program. Additionally, a system of risk corridors will be employed to ensure against higher-than-expected drug costs.[4]
- The Act also authorizes the program's administrator to take steps necessary to ensure that all beneficiaries have a choice of prescription drug plans.

Additional Assistance for Beneficiaries of Limited Means and with Low Incomes

Medicare beneficiaries of limited means and with income below 135 percent of poverty will be given immediate assistance through a Medicare-endorsed prescription drug discount card with $600 to apply toward purchasing their medicines. This discount card benefit will be in use until January 1, 2006, when the full prescription drug benefit goes into effect.

Once the full benefit begins in 2006, Medicare beneficiaries of limited means and with incomes below 150 percent of the Federal Poverty Level (FPL) will see additional savings under the Medicare prescription drug plan:

- The poorest beneficiaries—those with incomes below 100 percent of the FPL who are eligible for full benefits under Medicaid—will pay no premiums, no deductibles, and will pay cost-sharing of $1 for a generic drug or a preferred multiple-source drug and $3 for all other drugs. This includes the poorest nursing home residents who will have no co-payment requirements.
- All other seniors who are eligible for full benefits under Medicaid, as well as other seniors with incomes below 135 percent of FPL and assets of no more than $6,000 per individual and $9,000 per couple, will pay no premiums, no deductibles, and will pay nominal cost-sharing of $2 for a generic drug or a preferred multiple source drug and $5 for any other drug.
- Those with incomes below 150 percent FPL and assets of no more than $10,000 per individual and $20,000 per couple will get sliding scale subsidies for their premiums, and pay both a lower deductible ($50) and lower cost-sharing (15 percent) compared with the standard benefit.
- Seniors will be able to retain assets such as their house, automobile, and personal property (such as wedding rings); these items will not count toward the asset limit in determining their eligibility for either low-income subsidy group.

Approximately one-third of Medicare enrollees of limited means and with incomes below 150 percent of FPL will qualify for additional assistance. In many states, 40% and more of Medicare beneficiaries have limited savings and low incomes and will likely qualify for additional assistance. Many Medicare beneficiaries with incomes below 150 percent of poverty lack any drug coverage today, and thus promise to benefit significantly from this coverage.

Savings for State Governments and Employers

In addition to providing help to beneficiaries, provisions of the Act will help states by paying for most of the prescription drug costs for those who are enrolled in both the Medicare and Medicaid programs. In addition, states already operating drug assistance programs for seniors who do not qualify for Medicaid (including Pennsylvania, New York, New Jersey, Connecticut and Massachusetts) could benefit from reductions in drug spending.

For employers that offer their Medicare-eligible retirees prescription drug coverage, the legislation also provides a 28% subsidy for the cost of drugs used by each enrollee up to $5,000, after a $250 deductible is met. This provision will allow many seniors to continue the benefits they have today.

New Preventive Benefits with the Medicare Prescription Drug, Improvement, and Modernization Act

Beginning in 2005, all newly-enrolled Medicare beneficiaries will be covered for:

- An initial physical examination; and
- Cardiovascular screening blood tests.

In addition, those at risk will be covered for a diabetes screen. These new benefits for preventive procedures can be used to screen Medicare beneficiaries for many illnesses and conditions. If these illnesses can be caught early, they can be treated and managed before they lead to serious health consequences. Conditions such as obesity, diabetes,

heart disease, kidney disease, and asthma could be made far less severe for millions of Medicare beneficiaries. Early detection and treatment of chronic kidney disease can delay and at times prevent the onset of End-Stage Renal Disease (ESRD).

Current research indicates that preventive tests and screenings improve beneficiaries' lives and can reduce the need for more serious medical treatment.[5] Evidence is accumulating that much of the morbidity and mortality associated with these chronic diseases may be preventable. Providing initial health screenings to all new Medicare beneficiaries could lower overall Medicare spending now used to treat beneficiaries with these conditions.

Other Key Provisions of the Legislation

The National Institute of Diabetes and Digestive and Kidney Diseases will be required to conduct a clinical investigation of pancreatic islet cell transplantation. Payment for routine costs, as well as transplantation and appropriate related items and services for Medicare beneficiaries participating in the clinical trial, is to be paid by the Centers for Medicare & Medicaid Services (CMS). Routine costs will include reasonable and necessary routine patient care costs, immunosuppressive drugs, and other follow-up care.

End-Stage Renal Disease Composite Rate System

As a result of the MMA, CMS has released the following transmittal regarding End-Stage Renal Disease.

Transmittal: 101
Change Request (CR): 3119
Date: February 20, 2004
Effective Date: March 1, 2004
Implementation Date: April 1, 2004
Subject: Restoring Composite Rate Exceptions for Pediatric Facilities Under the End-Stage Renal Disease (ESRD) Composite Rate System

A hospital-based or independent pediatric renal dialysis facility may request CMS to approve an exception to the composite payment rate and set a higher payment rate if:

- The estimated allowable cost per treatment is higher than your composite rate; and
- The definition of a pediatric ESRD facility is met.

In accordance with MMA requirements, CMS has revised section 422(a)(2) of the Benefits Improvement and Protection Act of 2000 to:

- Provide that pediatric exception rates in effect on October 1, 2002 will continue in effect so long as the exception rate exceeds the facility's updated composite payment rate; and
- Restore the exceptions process for pediatric facilities only.

If a qualified facility did not have an approved exception rate as of October 1, 2002, MMA Section 623(b)(1)(D) allows them to submit a request for a new exception to their intermediary between April 1, 2004 and September 27, 2004.

The MMA also revises the definition of a pediatric ESRD facility. The statute defines the term "pediatric facility" to mean a renal facility in which at least 50% of the patients are under 18 years of age.

If a facility meets these criteria and projects, on the basis of prior years' cost and utilization trends, that they will have an allowable cost per treatment higher than your prospective rate, they may request CMS to approve an exception to that rate and set a higher payment rate.

CMS will adjudicate these exception requests in accordance with the exception criteria contained in 42 CFR 413.180 and the Provider Reimbursement Manual, Part I, Chapter 27. However, the pediatric exception request will be denied if:

- The request is not adequately justified in accordance with regulations or program instructions, and/or
- The request is not received by the intermediary before close of business on September 27, 2004.

An exception request is deemed approved unless CMS disapproves it within 60 working days after it is filed with the intermediary. The first day of this 60-working-day deadline is the date that the exception request, containing all of the required documentation, is filed with the intermediary.

Therefore, the request to the intermediary must be sent through a method which documents the date of receipt. A postmark or other similar date will not serve as documentation of the date of receipt.

The following table includes relevant MMA provisions related to ESRD:

Bill Provision	Implementation Date	Text Summary
623	January 1, 2005	Payment for renal dialysis services. Establishes basic case-mix adjusted PPS. PPS begins with services provided on January 1, 2005.
623	January 1, 2005	Payment for renal dialysis services. For 2005, pays acquisition costs for separately billed drugs and biologicals, for 2006 and thereafter, pays acquisition costs or under the ASP method for separately billed drugs and biologicals.

SECTION 3:

Kidney Dialysis

Dialysis Treatment Options

There are two types of dialysis that can be used: **peritoneal dialysis** and **hemodialysis.** You and your patients can decide what type of dialysis is best for them based on their situation.

Peritoneal Dialysis

Peritoneal dialysis treatment is used at home under the routine supervision of a dialysis facility. Peritoneal dialysis is the process of cleansing the body of waste products by diffusion through semi-permiable membranes in the abdomen. The process occurs when 1-3 liters of prescribed solution (dialysate) is introduced into and removed from the peritoneal cavity by means of a single lumen catheter that has been inserted through the abdominal wall and anchored externally. The types of chronic peritoneal dialysis are determined by various schedules:

- Continuous ambulatory peritoneal dialysis (CAPD) has dialysate present in the abdomen day and night with 4 – 5 exchanges (removal and replacement) of dialysate during the day.
- Continuous cycler-assisted peritoneal dialysis (CCPD) has dialysis begin at bedtime when the patient connects themselves to a machine that will drain and replace the dialysate in the patient's abdomen while he/she sleeps and leave dialysate in the abdomen during the day.
- Nocturnal intermittent peritoneal dialysis (NIPD) is CCPD with an increased number of exchanges (5-8) at night and the abdomen is drained and left "dry" (without dialysate) during the day.

Hemodialysis

Hemodialysis is a process of cleaning the blood of waste products when the kidneys can no longer perform this job. CMS is leading a national initiative to increase the use of arteriovenous (AV) fistulas in providing hemodialysis for Medicare beneficiaries. The most common AV fistula site is the forearm. Fistulas are the "gold standard" for establishing access to a patient's circulatory system in order to provide life sustaining

dialysis. They last longer, need less rework, and are associated with lower rates of infections and hospitalization, and death for Medicare beneficiaries than other types of access.

Other vascular access types include AV grafts (a synthetic catheter that is used to connect an artery to a vein usually in the arm) and venous catheters (a dual lumen catheter "permanently" inserted into a vein, usually the internal jugular or the subclavian vein, with an access port either just below or just above the skin). Grafts and catheters require more maintenance, may deliver less than optimal cleaning of the blood, lead to more infections and hospitalizations, and cost more in the long run. A temporary catheter may be needed for dialysis in an emergency or during the period when a fistula is "maturing."

Determining How Well Dialysis is Working

You can help your patients keep track of their hemodialysis and help them determine how well it is working by providing them with their URR or Kt/V number, depending on which test your dialysis facility uses.

In addition, Medicare has more detailed information on determining how well hemodialysis is working in a brochure called Know Your Number . . . Are You Getting Adequate Hemodialysis? This patient education brochure helps patients understand the importance of getting adequate dialysis and what they can do to improve the adequacy of their dialysis.

Call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy of this brochure. You can also read or print a copy of this brochure at http://www.medicare.gov. Select "Publications."

Self-Dialysis Training

Self-dialysis training is covered by Medicare Part B on an outpatient basis. Self-dialysis training costs more than dialysis treatments. The costs may be different from one dialysis facility to another, depending on the type of facility and where it's located. In the Original Medicare Plan, after a beneficiary pays the $110 Part B yearly deductible, Medicare Part B will pay 80% of the training costs. Your patient is responsible for the remaining 20% of coinsurance.

For example: If the cost per training session is $150.00, after your patient pays the $110 Part B yearly deductible:

- Medicare Part B pays 80% of the $150 (or $120 per session), and
- Your patient must pay the remaining 20% coinsurance (or $30 per session).

Home Dialysis

Beneficiaries have two payment options for home dialysis:

Method 1 – Working with Their Dialysis Facility
Under Method 1, a beneficiary must get all services, equipment, and supplies needed for home dialysis from his/her dialysis facility.

In the *Original Medicare Plan*, the amount that Medicare pays the dialysis facility for these items and services depends on the composite rate, a rate that is set in advance. After the beneficiary pays the $100 Part B yearly *deductible*, Medicare pays 80% of the composite rate. The patient is responsible for 20% coinsurance. Also, note that the Part B deductible for 2005 will increase to $110 as a result of the MMA legislation enacted on December 8, 2003.

Method 2 - Dealing Directly With a Supplier

Under Method 2, the beneficiary must get their dialysis equipment and supplies from one supplier, who must accept **assignment**.* This means that if the beneficiary is in the *Original Medicare Plan*, their supplier agrees to accept Medicare's fee as full payment. Their supplier must also have a written agreement with a dialysis facility to make sure that the patient gets all necessary home dialysis support services.

In the *Original Medicare Plan*, after the beneficiary pays the $100 Part B yearly **deductible**, Medicare will pay 80% of the Medicare-approved charges for the items and services, and the beneficiary pays the 20% coinsurance.

Under both Method 1 and Method 2, beneficiaries must get their support services from their dialysis facility in order for Medicare to pay. Medicare will pay the facility directly for these services.

The chart below specifies what the patient pays for home dialysis equipment, supplies, and support services in the *Original Medicare Plan* using the Method 1 and Method 2 payment options.

*For more information on how assignment works, call 1-800-MEDICARE (1-800-633-4227) to get a free copy of "Does Your Doctor or Supplier Accept Assignment?" You can also read or print a copy of this booklet at http://www.medicare.gov/Publications/ on the Medicare web site.

Method 1 and Method 2 Payment Chart for Home Dialysis Equipment, Supplies, and Support Services in the *Original Medicare Plan*			
	Home Dialysis Equipment	Home Dialysis Supplies	Home Dialysis Support Services
Dealing With the Dialysis Facility (Method 1)	Medicare pays 80% of the facility's composite rate. The patient pays the 20% coinsurance.*	Medicare pays 80% of the facility's composite rate. The patient pays the 20% coinsurance.*	Medicare pays 80% of the facility's composite rate. The patient pays the 20%

Method 1 and Method 2 Payment Chart for Home Dialysis Equipment, Supplies, and Support Services in the *Original Medicare Plan*			
	Home Dialysis Equipment	Home Dialysis Supplies	Home Dialysis Support Services
Dealing Directly With a Supplier (Method 2)	If the patient buys or rents home dialysis equipment, Medicare Part B will cover it. The patient must pay the $100 Part B yearly deductible. Medicare Part B usually makes monthly payments. If the patient buys the equipment, Medicare will pay 80% of the monthly payment purchase price. The patient pays the 20% coinsurance. The monthly Part B payment includes any interest or carrying charges If you rent the equipment, Medicare Part B pays 80% of the approved monthly rental charge. The patient pays the 20% coinsurance	After the patient pays the $100 Part B yearly deductible, Medicare Part B pays 80% of the approved charges for all covered supplies. The patient pays the 20% coinsurance.	After the patient pays the $100 Part B yearly deductible, Medicare Part B pays the facility 80% of the approved charges for all covered services. The patient pays the 20% coinsurance.

* Each year, a beneficiary pays a total of one, $100 Part B deductible, but this deductible increases to $110 in 2005 as a result of the MMA.

Deciding Which Payment Option to Choose For Home Dialysis

The Method 1 and Method 2 payment chart can be used to help your patients decide which payment option is best for them if they are in the *Original Medicare Plan*, and they can also ask their social worker to help them decide.

After a beneficiary has finished self-dialysis training and is ready to make a choice, he or she must:

1. Fill out a Beneficiary Selection Form HCFA-382;
2. Sign Form HCFA-382; and
3. Return Form HCFA-382 to his or her dialysis facility.

Beneficiaries can get a copy of Form HCFA-382 from their dialysis facility. Once they make their choice and turn in the form, they must stay with that payment option until December 31 of that year. For example, if they decide to go with the Method 2 payment option in March 2004, they must stay with that option until December 31, 2004.

They can change from one method to the other by filling out a new Form HCFA-382 at any time, but the change will not start until the following January 1. For example, if your patient fills out a Form HCFA-382 to change to Method 1 and returns it to their dialysis facility in October 2004, this change will not start until January 1, 2005.

Important: No matter which method is chosen, a beneficiary can still make a change to get their treatment at a dialysis facility or to choose another facility.

How Long Medicare Will Pay For Home Dialysis Equipment

Medicare Part B will pay for home dialysis equipment as long as dialysis at home is needed. When home dialysis is no longer needed, Part B will stop paying for it. For example, if a patient has a kidney transplant and no longer needs home dialysis, then Part B will stop paying for his or her equipment.

If a beneficiary buys dialysis equipment, Part B payments will stop once the Medicare-approved purchase price is reached. For example, if Medicare agrees to pay $200 for dialysis equipment, Part B payments will stop once Medicare pays $200.

What is Covered by Medicare

*Medicare covers these dialysis services and pays **part** of their costs:*

Service or Supply	Medicare Part A	Medicare Part B
Inpatient dialysis treatments (if admitted to a hospital for special care)	Yes	
Outpatient dialysis treatments (treatments in any Medicare-approved dialysis facility)		Yes
Self-dialysis training (including instruction for the beneficiary and for the person helping with their home dialysis treatments)		Yes
Home dialysis equipment and supplies (like alcohol, wipes, sterile drapes, rubber gloves, and scissors)		Yes
Certain home support services (may include visits by trained hospital or dialysis facility workers to check on home dialysis, to help in emergencies when needed, and to check dialysis equipment and water supply)		Yes
Certain drugs for home dialysis		Yes
Outpatient doctors' services		Yes
Most other services and supplies that are a part of dialysis, such as laboratory tests		Yes

Home Dialysis Drugs Covered by Medicare

Medicare Part B covers the following common drugs for home dialysis:

- Heparin
- The antidote for heparin when medically necessary
- Topical anesthetics
- Epoetin Alfa (Epogen, EPO)
- Darbepoetin Alfa (Aranesp).

What is Not Covered by Medicare

Medicare does **not pay** for the following:

- Paid dialysis aides to help with home dialysis
- Any lost pay to the beneficiary and the person who may be helping them during self-dialysis training
- A place to stay during treatment
- Blood or packed red blood cells for home self dialysis unless part of a doctors' service or is needed to prime the dialysis equipment
- Transportation to the dialysis facility (see page 20 for coverage in special cases)

What Your Medicare Patients Pay for Dialysis Services

The costs listed in this section are for dialysis services in the *Original Medicare Plan*. If patients are in *Medicare managed care plans* or *Private Fee-for-Service plans*, their costs may be different. Their plan materials or their benefits administrator can provide information about their costs.

Dialysis in a Dialysis Facility

In the *Original Medicare Plan*, if a beneficiary gets dialysis in a Medicare-approved facility, Medicare Part B pays the facility for dialysis-related services on a per-treatment rate (called the composite rate). This rate may be different from one dialysis facility to another, depending on the type of facility and where it's located. Medicare pays 80% of the composite rate. The patient is responsible for the remaining 20% coinsurance that Medicare does not pay.

Example: The composite rate is $130 per treatment. If the beneficiary has already satisfied the $100 Part B yearly deductible:

- Medicare Part B pays the facility 80% of $130 (or $104).
- The beneficiary pays the remaining 20% coinsurance (or $26).

There may be other services that are not included in the composite rate. The dialysis facility can provide a list of tests and other services that are included in this rate. For services not included in the composite rate, Medicare pays 80% of the **Medicare-approved amount**. The patient is responsible for 20% **coinsurance**.

Dialysis in a Hospital

If a beneficiary is admitted to a hospital and gets dialysis, treatments will be covered by Medicare Part A as part of the costs of covered inpatient hospital stay. (See the Medicare Part A coverage chart on page 37.)

Doctors' Services

Outpatient Doctors' Services

In the *Original Medicare Plan*, Medicare pays the doctor once a month. The same monthly amount is paid for each patient the doctor cares for, whether dialysis is performed in the home or in a dialysis facility. After the patient satisfies the $100 Part B yearly deductible, Medicare Part B pays 80% of the monthly amount, and the patient is responsible for the remaining 20% coinsurance.

Example: The monthly amount that Medicare pays a doctor for each patient is $100. After the beneficiary pays the $100 Part B yearly deductible:

- Medicare pays 80% of the $100 (or $80).
- The beneficiary pays the remaining 20% coinsurance (or $20).

Inpatient Doctors' Services

In the *Original Medicare Plan*, a doctor can choose to be paid in one of two ways for a beneficiary's inpatient hospital care:

1. Continue to receive monthly payment (the same payment for outpatient doctors' services). In this case, the beneficiary must pay 20% of the **Medicare-approved amount** after the deductible, except in the outpatient setting.
2. Bill separately for inpatient services that are covered by Medicare Part A. In this case, the doctor's monthly payment will be less, based on the number of days the beneficiary stays in the hospital. (See the Medicare Part A coverage chart on page 37.)

Dialysis When Patients are Traveling

Beneficiaries should plan for their dialysis treatment along the routes of their trips before they travel, and their dialysis facility will help them with these plans. Before they make their plans, however, your dialysis patients should consider the following:

- Is the dialysis facility approved by Medicare to give dialysis?
- Does the facility have the space and time to give the patient care when needed?
- Does the facility have enough information about the beneficiary to give them the right treatment?
- Where is the facility located?

There are over 3,500 facilities around the country. The beneficiary's facility or the ESRD Network may be able to identify a facility for the patient. Also, the CMS website, http://www.medicare.gov/contacts/home.asp includes the names and addresses of facilities nationwide.

Information about Medicare-certified dialysis facilities can also be found at http://www.medicare.gov. Select "Search Tools and Click on "Dialysis Facility Compare."

In general, Medicare will pay only for hospital or medical care that is provided in the United States.

Does the beneficiary get dialysis services from a Method 2 supplier (see page 17) or a Medicare managed care plan? If so, their supplier or managed care plan may be able to help them get the dialysis they need while they travel. **They may have to pay all of the costs for their dialysis treatments**. They can contact their supplier or health plan for more information.

Transportation to Dialysis Facilities

In most cases, Medicare will not pay for transportation to dialysis facilities. Medicare covers roundtrip ambulance services from home to the nearest dialysis facility **only** if other forms of transportation would be harmful to the beneficiary's health.

The ambulance supplier must get a written order from the patient's primary doctor before providing the ambulance service. The doctor's written order must be dated no earlier than 60 days before the patient obtains the ambulance service.

SECTION 4:

Kidney Transplants

What is Covered by Medicare

Medicare covers these transplant services and pays part of their costs:

Service or Supply	Medicare Part A	Medicare Part B
Inpatient hospital services in an approved hospital (see the Medicare Parts A and B coverage charts on pages 35-40)	Yes	
Kidney Registry Fee	Yes	
Laboratory and other tests needed to evaluate the beneficiary's medical condition*	Yes	
Laboratory and other tests needed to evaluate the medical conditions of potential kidney donors*	Yes	
The costs of finding the proper kidney for transplant surgery (if there is no kidney donor)	Yes	
The full cost of care for the kidney donor (including all reasonable preparatory, operation, and postoperative recovery costs)	Yes	
Any additional inpatient hospital care for the donor in case of problems due to the surgery	Yes	
Doctors' services for kidney transplant surgery (including care before surgery, the actual surgery, and care after surgery)		Yes
Doctor's services for the kidney donor during their hospital stay		Yes
Immunosuppressive drugs (for information on length of coverage, see the next section below)		Yes
Blood (whole or units of packed red blood cells, blood components, and the cost of processing and giving blood, see page 25)	Yes	Yes

*These services are covered whether they are performed by the Medicare-approved hospital where the beneficiary will get his or her transplant, or by another hospital that participates in Medicare.

Note: Medicare does not pay for the actual kidneys for a transplant. Buying or selling human organs is against the law.

Transplant Drugs (Immunosuppressive Drugs)

Payment for Transplant Drugs

If beneficiaries have Medicare only because of kidney failure, their Medicare will end 36 months after the month of the transplant.

Medicare will not pay for any services (including immunosuppressive drugs for patients) who are not entitled to Medicare. If beneficiaries already had Medicare because of age or disability before they got ESRD, or if they became eligible for Medicare because of age or disability after receiving a transplant that was paid for by Medicare or paid for by private insurance that paid primary to their Medicare Part A Coverage (in a Medicare-certified facility), Medicare will continue to pay for their immunosuppressive drugs with no time limit.

If a beneficiary has Medicare only because of kidney failure, this does not apply to them. Their Medicare and drug coverage will end when their 36-month period is up.

Inability to Pay for Transplant Drugs

Transplant drugs can be very costly. If beneficiaries have Medicare only because of kidney failure, immunosuppressive drugs are covered for only 36 months after the month of the transplant. If beneficiaries are worried about paying for the drugs, they should talk with their health care team. There may be other ways to help them pay for these drugs. (See pages 29-33 to learn more about other health insurance.)

Special Information About Pancreas Transplants

If a beneficiary has ESRD and needs a pancreas transplant, Medicare covers the transplant:

- When it is done at the same time the beneficiary gets a kidney transplant, or
- After a kidney transplant.

If a beneficiary has Medicare only because of kidney failure, and he/she has the pancreas transplant after the kidney transplant, Medicare will pay for immunosuppressive drug therapy for 36 months after the month of the pancreas transplant.

If beneficiaries already had Medicare because of age or disability before they got ESRD, or if they became eligible for Medicare because of age or disability after receiving a transplant, Medicare will continue to pay for their immunosuppressive drugs with no time limit.

If the beneficiay has diabetes and their diabetes did not cause their kidney failure, this coverage does not apply to them.

What the Medicare Patient Pays for Kidney Transplant Services

The amounts listed in this section are for transplant services in the *Original Medicare Plan*. If a beneficiary is in a *Medicare Advantage Plan,* their costs may be different. They should read their plan materials or call their benefits administrator to get cost information.

Paying for Kidney Donors

The patient does not have to pay for the kidney donor. Medicare will pay the full cost of care for the beneficiary's kidney donor. There is no deductible, coinsurance, or other costs that they have to pay for the donor's hospital stay.

Doctors' Services

In the *Original Medicare Plan*, a beneficiary must pay the $110 Part B yearly **deductible**. After your patient pays the deductible, Medicare Part B pays 80% of the Medicare-approved amount. The patient is responsible for the remaining 20% coinsurance.

Important: There is a limit on the amount a doctor can charge the beneficiary, even if the doctor doesn't accept **assignment**. If the doctor does not accept assignment, the patient only has to pay the part of the bill that is over the **Medicare-approved amount**, up to the limit that Medicare allows their doctor to charge.

Call 1-800-MEDICARE (1-800-633-4227) to get a free copy of "Does your doctor or supplier accept assignment?" This document can also be found at http://www.medicare.gov/Publications/ on the Medicare web site. This booklet will provide detailed information on how assignment works.

Note: See the chart on page 37 for details about what a beneficiary pays under Medicare Part A.

SECTION 5:

How Medicare Pays for Blood

In most cases, Medicare Part A and B can help pay for:

- Whole blood units or packed red blood cells;
- Blood components; and
- The cost of processing and giving blood.

Medicare does not pay for blood for home self-dialysis unless it's part of a doctor's service or is needed to prime the dialysis equipment.

What Medicare Beneficiaries Pay for Blood

Under Medicare Part A, beneficiaries pay for the first three units of whole blood or units of packed red cells that they get during a benefit period while they are staying in a hospital or skilled nursing facility. They can choose to either pay the hospital costs for the blood or packed red cells, or they can have the blood replaced (see "How to Have Blood Replaced," in the next section below).

Note: If a beneficiary paid for or replaced some units of blood under Medicare Part B during the calendar year (January 1 through December 31), he/she doesn't have to do so again under Medicare Part A.

Under **Medicare Part B**, beneficiaries pay for the first three units of whole blood or units of packed red cells that they get in a calendar year. They can choose to either pay the hospital costs for the blood or packed red cells or they can have the blood replaced (see "How to Have Blood Replaced," in the next section below).

In the Original Medicare Plan, Medicare Part B pays 80% of the approved charges for extra pints of blood in a calendar year. A beneficiary is responsible for the remaining 20% coinsurance.

Note: If a beneficiary has paid for or replaced blood under Medicare Part A during a calendar year (January 1 through December 31), he/she doesn't have to do so again under Medicare Part B.

How to Have Blood Replaced

Beneficiaries can replace the blood by donating their own blood, or getting another person or organization to replace the blood for them. The blood that is replaced does not have to match your patient's blood type. If your patient decides to replace the blood through a self-donation, Medicare suggests they check with you first before donating blood.

Can a Beneficiary be Charged for the Blood That They Have Replaced?

A hospital or skilled nursing facility can not charge for any of the first three pints of blood replaced or that which will be replaced. Also, if a beneficiary's provider receives donated blood or red cells, they are considered replaced.

SECTION 6:

Appeals and Grievances—(Complaints)

Appeals

Medicare beneficiaries have certain guaranteed rights to help protect them. One of these is the right to a fair, efficient, and timely process for appealing decisions about health care payment or services. Whether a beneficiary is in the Original Medicare Plan or a Medicare Advantage Plan, they always have the right to appeal. Some of the reasons a beneficiary may appeal including the following:

- He/she does not agree with the amount that is paid;
- A service or item isn't covered, and he/she thinks it should be covered; or
- A service or item is denied, and he/she thinks it should be paid.

Appeal Rights in the Original Medicare Plan

If the beneficiary is in the Original Medicare Plan, he/she can file an appeal for any of the reasons listed above. If the beneficiary files an appeal, he/she should ask their doctor or provider for any information related to the bill that might help with their case. A beneficiary's appeal rights are on the back of the Medicare Summary Notice that is mailed to them from a company that handles bills for Medicare. The notice will also inform the beneficiary why Medicare didn't pay their bill and how they can appeal.

Appeal Rights in a Medicare Advantage Plan

If the beneficiary is in a Medicare Advantage Plan, he/she can file an appeal for any of the reasons listed above. Also, the beneficiary can see their plan's membership materials or contact their plan for details about Medicare appeal rights. They may also call 1-800-MEDICARE (1-800-633-4227) to ask for more information about their rights during an appeal. TTY users should call 1-877-486-2048.

Filing a Grievance (Complaint)

Beneficiaries should talk with their doctors, nurses, or facility administrators first to seek help in solving their problem. Most problems can be handled at the facility. If the beneficiaries' health care teams do not solve the problem, they can file **grievances** (a written complaint) with their facility.

Every facility has a grievance policy for accepting and attempting to resolve a patient's problems or concerns. If a patient does not know his or her facility's grievance policy, he or she can ask for a copy of it.

If a patient files a grievance with his/her facility but continues to believe the problem has not been solved, the patient has the right to file a grievance with the ESRD Network in his or her area. The patient can call the ESRD Network to find out what to do in order to file a grievance. (go to http://www.medicare.gov/contacts/home.asp on the CMS web site.)

Patients can also call their State Survey Agency to complain about their care. **Their identity and the content of their calls will be kept private**.

Contact information for State Survey Agencies can be found by calling 1-800-MEDICARE (1-800-633-4227) or by visiting http://www.medicare.gov and selecting "Helpful Contacts."

SECTION 7:

Other Kinds of Health Insurance

There are several kinds of health insurance coverage that may help pay for the services your patient needs for the treatment of kidney failure. These include:

- Employee or Retiree Coverage from an Employer or Union
- A Medigap Insurance Policy
- Medicare Health Plan Choices
- Medicaid
- Veterans Administration Benefits

Employee or Retiree Coverage from an Employer or Union

This type of group health coverage is for current employees or retirees. Generally, employer plans have better rates than an employee can get if they buy a policy themselves, and employers pay part of the cost. Patients can call their benefits administrators to find out if they have or can get health care coverage based on their or their spouse's past or current employment, or their parents' current employment. In some cases, employer group health plans will have to pay before Medicare pays.

How Medicare Works With Employer Group Health Plan Coverage

If a patient is eligible for Medicare only because of permanent kidney failure, his or her Medicare coverage usually will not start until the fourth month of dialysis. Medicare will not pay anything during the patient's first three months of dialysis unless the patient already has Medicare because of age or disability. Therefore, his or her employer group health plan is the only payer for the first three months of dialysis.*

When a patient is able to get Medicare because of kidney failure (usually the fourth month of dialysis), there is a period of time when the patient's employer group health plan will pay first on his or her health care bills and Medicare will pay second. This period of time is called a 30-month coordination period.

This means that if the patient's employer plan doesn't pay 100% of his or her health care bills during the 30-month coordination period, Medicare may pay for the remaining costs. Medicare is called the secondary payer during this coordination period.

* If a patient's employer plan does not pay all costs for dialysis, the patient may have to pay some of the costs. Patients may be able to get help to pay these costs.

When the 30-Month Coordination Period Starts

The 30-month coordination period starts the first month a patient is able to get Medicare because of kidney failure (usually the fourth month of dialysis), even if the patient is not enrolled in Medicare yet. For example, if a patient starts dialysis in June, the 30-month coordination period will start September 1, the fourth month of dialysis.

If a patient takes a course in self-dialysis training or gets a kidney transplant during the three-month waiting period, the 30-month coordination period will start with the first month of dialysis or kidney transplant. During this time, Medicare will be the secondary payer.

Important: If a patient has employer group health plan coverage during the 30-month coordination period, the patient should advise you of this fact to ensure that his or her services are billed correctly.

What Happens When the 30-Month Coordination Period Ends

At the end of the 30-month coordination period, Medicare will pay first for all Medicare-covered services. The patient's employer group health plan coverage may pay for services not covered by Medicare, and the patient can check with his or her plan's benefits administrator to help answer any additional questions.

How the 30-Month Coordination Period Works if Your Patient Enrolls in Medicare More Than Once

There is a separate 30-month coordination period each time a patient enrolls in Medicare based on kidney failure. For example, if the patient gets a kidney transplant that continues to work for 36 months, Medicare coverage will end.

If after 36 months the patient enrolls in Medicare again because he or she started dialysis again or gets another transplant, Medicare coverage will start right away. There will be no three-month waiting period before Medicare begins to pay, and there will be a new 30-month coordination period if the patient has employer group health plan coverage.

Do Patients Have to Get Medicare Because Their Kidneys Fail, if They Already Have Employer Group Health Plans?

No, but patients should think carefully about this decision. If a patient already has an employer group health plan, consider the following:

1. If they get a kidney transplant, Medicare will cover their immunosuppressive drugs (see page 23) only if:

- The patient has Medicare Part A at the time of the transplant, and the transplant is paid for by Medicare; or
- The patient has Medicare Part A at the time of the transplant, and Medicare doesn't pay for the transplant because Medicare is secondary payer to the patient's employer group health plan; or
- The patient has Medicare Part A at the time of the transplant, and the patient becomes eligible for Medicare because of age or disability.

In both instances, the transplant surgery must have taken place in a Medicare-approved facility. In addition to the above conditions, the patient must have Medicare Part B coverage at the time they receive the immunosuppressive drugs.

2. If the patient's group health plan coverage has a yearly deductible or a coinsurance to pay, enrolling in Medicare Parts A and B could help pay those costs.

3. If the patient's group health plan coverage doesn't have a yearly deductible or a coinsurance and will pay all of their health care costs, the patient may want to delay enrolling in Medicare Part A and Part B until the 30-month coordination period is over. Delaying enrollment means that they will not be paying the Part B premium. After the 30-month coordination period, the patient should enroll in Medicare.

For more information about how employer group health plan coverage works with Medicare, patients should

- Get a copy of their plan's benefits booklet, or
- Call their benefits administrator and ask how the plan pays when they have Medicare.

A Medigap Insurance Policy

A "Medigap" insurance policy fills gaps in Original Medicare Plan coverage. Medigap insurance must follow federal and state laws. These laws protect the patient. All Medigap policies are clearly marked "Medicare Supplement Insurance."

Some insurance companies will sell Medigap policies to people with Medicare who are under age 65. However, these policies may cost more. Beneficiaries should call their State Health Insurance Assistance Program for information about buying Medigap policies if they are disabled or have ESRD

For State Health Insurance Assistance Program contact information, beneficiaries can visit http://www.medicare.gov/contacts/home.asp on the Medicare web site.

For more detailed information about Medigap policies, beneficiaries can call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy of the "Guide to Health Insurance for People with Medicare."

They can also visit http://www.medicare.gov on the Internet to get information on Medigap policies in their state. Select "Medigap Compare." This website has information about:

- Medigap policies sold in their state;
- Comparing Medigap policies;
- What each policy covers;
- Out-of-pocket costs for the beneficiary.

If the beneficiary doesn't have a computer, the local library or senior center may be able to help them find this information.

Medicare Health Plan Choices

Today's Medicare is about choice, and health plan choices include:

- The Original Medicare Plan (also known as fee-for-service) available nationwide.
- Medicare Advantage Plans (new name for Medicare + Choice) including:
  - o Medicare Managed Care Plans,
  - o Medicare Private Fee-for-Service Plans, and
  - o Medicare Preferred Provider Organization Plans.

A beneficiary may not be able to join a Medicare Advantage Plan if they have End-Stage Renal Disease. Patients with ESRD who start dialysis and are already in a Medicare Advantage Plan can stay in the plan they are in or join another plan offered by the same company in the same state. They must continue to pay the monthly Part B premium of $78.20* in 2005.

If a patient had a successful kidney transplant, he or she may be able to join a plan, and can call 1-800-MEDICARE (1-800-633-4227) for more information about End-Stage Renal Disease and Medicare health plans. If a patient has ESRD and he/she is in a plan and the plan leaves Medicare or no longer provides coverage in the patient's area, they can join another Medicare Advantage Plan if one is available in their area.

For more information about your Medicare health plan choices, your patient can call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy of the Medicare & You handbook. TTY users should call 1-877-486-2048. They can also read or print a copy of this handbook at www.medicare.gov on the web. Select "Publications."

*Any change in the Part B premium amount will be available on January 1st of each year.

Medicaid

Medicaid is a joint federal and state program that helps pay medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state. Most health care costs are covered if the person qualifies for both Medicare and Medicaid.

States also have programs that pay some or all of Medicare premiums and may also pay Medicare deductibles and coinsurances for certain low-income people who have Medicare. To qualify for these programs, a beneficiary must:

- Have Medicare Part A (hospital insurance). If the beneficiary is not sure they have Part A, they can look on their red, white, and blue Medicare card or call the Social Security Administration at 1-800-772-1213.
- Have a monthly income of less than $1,068 for an individual or $1,426 for a couple in 2004. These income limits are slightly higher in Hawaii and Alaska. Income limits will change slightly in 2005.
- Have savings of $4,000 or less for an individual or $6,000 for a couple. Savings include money in a checking or savings account, stocks, or bonds.

For more information about these programs, beneficiaries can call 1-800-MEDICARE (1-800-633-4227; TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) and ask for information about "Savings for People with Medicare."

Veterans Administration Benefits

If the patient is a veteran, the U.S. Department of Veterans Affairs can help pay for ESRD treatment. For more information, the veteran can call the U.S. Department of Veterans Affairs at 1-800-827-1000. If the veteran or their spouse retired from the military, he or she can call the Department of Defense at 1-800-538-9552 for more information.

Other Ways to Get Help

Most states have agencies that help with some of the health care costs that Medicare doesn't pay. Some states have Kidney Commissions that also help people pay the costs that Medicare doesn't pay. Patients can call their State Health Insurance Assistance Program if they have questions about health insurance. Contact information is located at http://www.medicare.gov/contacts/home.asp on the Medicare web site.

SECTION 8:

Where to Get More Information

Patients should talk with their health care team—doctors, nurses, social workers, dieticians, and dialysis technicians—to learn more about kidney dialysis and transplants and the specifics of their situation. Sources for more information are listed below.

Special Kidney Organizations

There are special organizations that can provide more information about kidney dialysis and kidney transplants. Some of these organizations have members who are on dialysis or have had kidney transplants and who can provide support.

American Association of Kidney Patients

3505 E. Frontage Road., Ste. 315
Tampa, Florida 33607
1-800-749-2257
info@aakp.org
http://www.aakp.org

National Kidney Foundation, Inc.

30 E. 33rd Street, Suite 1100
New York, NY 10016
1-800-622-9010
http://www.kidney.org

American Kidney Fund

6110 Executive Blvd, Suite 1010
Rockville, MD 20852-3903
1-800-638-8299
http://www.akfinc.org

National Kidney and Urologic Diseases

Information Clearinghouse
NKDEP
Office of Communications and Public Liaison, NIDDK, NIH, Building 31, Room 9A06
31 Center Drive, MSC2560
Bethesda, MD 20892-2560
1-800-891-5390 or 1-301-654-4415
http://www.niddk.nih.gov

End-Stage Renal Disease (ESRD) Networks

The local ESRD Network Organization (see the CMS Website at http://www.medicare.gov/contacts/home.asp) can provide information about:

- Dialysis or kidney transplants;
- How to get help from other kidney-related agencies;
- Problems with facilities that are not solved after talking to the staff at the facility;
- Location of dialysis facilities and transplant centers.

The ESRD Network makes sure that patients are getting the best possible care and uses mailings to keep facilities aware of important issues about kidney dialysis and transplants.

State Programs

State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (see the CMS Website at http://www.medicare.gov/contacts/home.asp) can be contacted for questions about:

- Medigap policies;
- Medicare health plan choices;
- Help with filing an appeal;
- Other general health insurance questions.

State Survey Agency

The State Survey Agency inspects dialysis facilities and ensures that Medicare standards are met. The State Survey Agency can also help with complaints about a patient's care. Patients can call 1-800-MEDICARE (1-800-633-4227) and ask for the number for their State Survey Agency, or go to http://www.medicare.gov and select "Helpful Contacts." All calls are kept private.

Other Medicare Booklets for Kidney Patients

Medicare has two booklets useful for kidney patients

"Know Your Number . . . Are You Getting Adequate Hemodialysis?"

This booklet tells the beneficiary how to determine how well their dialysis is working. It also tells them what to do if they're not getting the right amount of dialysis.

"Preparing for Emergencies, A Guide for People on Dialysis."

This guide provides important facts about what to do in case of an emergency that leaves patients without power or water. It describes the information beneficiaries should have ready, provides lists of supplies to have on hand to prepare for emergencies, and gives helpful ideas on how to manage until conditions return to normal.

Patients can get free copies of these booklets by calling 1-800-MEDICARE (1-800-633-4227; TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) or by viewing or printing copies online, from http:www.medicare.gov. (Select "Publications.")

ESRD Networks and State Health Insurance Assistance Program phone numbers can be found at http://www.medicare.gov/contacts/home.asp on the CMS web site. To get the most updated phone numbers, call 1-800-MEDICARE (1-800-633-4227; TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) or go to http://www.medicare.gov and select "Helpful Contacts."

SECTION 9:

Medicare Coverage Charts

Medicare Part A Coverage

Medicare Part A (Hospital Insurance) Helps Pay For:	What the patient pays in 2004* in the *Original Medicare Plan*
Hospital Stays: Semiprivate room, meals, general nursing, and other hospital services and supplies. This includes inpatient care in critical access hospitals and mental health care. This doesn't include private duty nursing, or a television or telephone in the patient's room. It also doesn't include a private room, unless medically necessary. Inpatient mental health care in a psychiatric facility is limited to 190 days in a lifetime.	**For each benefit period:** • A total of $912 for a hospital stay of 1–60 days. • $228 per day for days 61–90 of a hospital stay. • $456 per day for days 91–150 of a hospital stay. • All costs for each day beyond 150 days.
Skilled Nursing Facility (SNF) Care **Semiprivate room, meals, skilled nursing and rehabilitative services, and other services and supplies (after a related three-day hospital stay).	**For each benefit period:** • Nothing for the first 20 days. • Up to $114.00 per day for days 21–100. • All costs beyond the 100th day in the benefit period. For questions about SNF care and conditions of coverage, call 1-800-MEDICARE (1-800-633-4227).

Medicare Part A (Hospital Insurance) Helps Pay For:	What the patient pays in 2004* in the *Original Medicare Plan*
Home Health Care: **Part-time or intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech-language therapy, medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services.	**The patient pays:** • Nothing for **Medicare-approved** services. • 20% of the **Medicare-approved** amount for durable medical equipment. For questions about home health care and conditions of coverage, call 1-800-MEDICARE (1-800-633-4227).
Hospice Care: **For beneficiaries with a terminal illness, includes drugs for symptom control and pain relief, medical and support services from a Medicare-approved hospice, and other services not otherwise covered by Medicare. Hospice care is usually given in the beneficiary's home (may include a nursing home if that's the patient's home). However, Medicare covers some short-term hospital and inpatient respite care (care given to a hospice patient so that the usual caregiver can rest).	**The patient pays:** • A copayment of up to $5 for outpatient prescription drugs and 5% of the Medicare-approved amount for inpatient respite care. The amount the beneficiary pays for respite care can change each year. Medicare generally doesn't pay for room and board except in certain cases. For example, room and board aren't covered if the beneficiary gets general hospice services while a resident of a nursing home or a hospice's residential facility. However, room and board are covered for inpatient respite care and during short-term hospital stays.
Blood: Pints of blood provided at a hospital or skilled nursing facility during a covered stay.	**The patient pays:** • For the first three pints of blood, unless the beneficiary or someone else donates blood to replace what the beneficiary used.

* New Part A and B amounts will be available by January of each year.

** Note: Actual amounts the beneficiary must pay may be higher if the doctor or supplier doesn't accept assignment and the beneficiary may have to pay the entire charge at the time of service. Medicare will then send the beneficiary its share of the charge. If there are general questions about Medicare Part B, call your Medicare carrier/intermediary. If you have questions about durable medical equipment, including diabetic supplies, call your Durable Medical Equipment Regional Carrier (DMERC). For their telephone numbers, go to http://www.medicare.gov on the web. Select "Helpful Contacts." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Medicare Part B Coverage Chart

Medicare Part B (Medical Insurance) Helps Pay For:	What The patient pays in 2004* in the *Original Medicare Plan* (see Note below)
Medical and Other Services: Doctors' services (not routine physical exams), outpatient medical and surgical services and supplies, diagnostic tests, ambulatory surgery center facility fees for approved procedures, and durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers). Also covers a second and third surgical opinion for surgery that isn't an emergency, outpatient mental health care, and outpatient physical and occupational therapy, including speech-language therapy. (These services are also covered for long-term nursing home residents.)	**The patient pays:** • $110 deductible (once per calendar year). • 20% of the Medicare-approved amount after the deductible (if the doctor or provider accepts "assignment"). • 20% for all outpatient physical, occupational, and speech-language therapy services. • 50% for most outpatient mental health care.
Clinical Laboratory Service: Blood tests, urinalysis, some screening tests, and more.	**The patient pays:** • Nothing for Medicare-approved services.
Home Health Care: ** Part-time or intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech-language therapy, medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services.	**The patient pays:** • Nothing for Medicare-approved services. • 20% of the Medicare-approved amount for durable medical equipment. For questions about home health care and conditions of coverage, patients can call their Regional Home Health Intermediary.**
Outpatient Hospital Services: Hospital services and supplies received as an outpatient as part of a doctor's care.	**The patient pays:** • A **coinsurance** or co-payment amount which may vary according to the service.
Blood: Pints of blood the patient gets as an outpatient or as part of a Part B covered service	**The patient pays:** • For the first three pints of blood, then 20% of the Medicare-approved amount for additional pints of blood (after the deductible), unless the patient or someone else donates blood to replace what the patient used.

* New Part A and B amounts will be available by January of each year.

** Note: Actual amounts the beneficiary must pay may be higher if the doctor or supplier doesn't accept assignment and the beneficiary may have to pay the entire charge at the time of service. Medicare will then send the beneficiary its share of the charge. If there are general questions about Medicare Part B, patients should call

their Medicare carrier/intermediary. For questions about durable medical equipment, including diabetic supplies, patients can call their Durable Medical Equipment Regional Carrier (DMERC). For their telephone numbers, look at http://www.medicare.gov on the web. Select "Helpful Contacts." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Medicare Part B Preventive Services

Medicare Part B Covered Preventive Services	Who is covered	What the patient pays in the *Original Medicare Plan*
Bone Mass Measurements: Once every 24 months for qualified individuals and more frequently if medically necessary.	Certain people with Medicare who are at risk for losing bone mass.	20% of the **Medicare-approved amount** (or a co-payment amount) after the yearly Part B **deductible**.
Cardiovascular Screening: The Medicare beneficiary should talk with their doctor about how often they can get these screening tests. Includes blood tests to check cholesterol, lipid or triglyceride levels, and other tests for early detection of, or to identify a high risk for developing cardiovascular disease.	Medicare beneficiary should discuss with their doctor to see if they qualify.	Nothing for lab tests. For all other tests, 20% of the Medicare-approved amount after the yearly Part B deductible.

Medicare Part B Covered Preventive Services	Who is covered	What the patient pays in the *Original Medicare Plan*
Colorectal Cancer Screening: • Fecal Occult Blood Test (FOBT) - Once every 12 months. • Flexible Sigmoidoscopy* - Once every 48 months. • Colonoscopy* - Once every 24 months for beneficiaries at high risk for colon cancer. If not at high risk for colon cancer, once every 10 years, but not within 48 months of a screening flexible sigmoidoscopy. • Barium Enema - Doctor can use this instead of a flexible sigmoidoscopy or colonoscopy. It is covered every 24 months if the beneficiary is at high risk for colorectal cancer and every 48 months if they are not at high risk.	All people with Medicare age 50 and older. However, there is no minimum age limit for having a colonoscopy.	Nothing for the fecal occult blood test (FOBT). For all other tests, 20% of the Medicare-approved amount after the yearly Part B deductible. For flexible sigmoidoscopy or colonoscopy, the beneficiary pays 25% of the Medicare-approved amount after the yearly Part B deductible if the test is done in a hospital outpatient department.
Diabetes Services: • Diabetes Screening Tests – Beneficiaries should talk with you, their doctor, regarding how often they can get these screening tests. Includes fasting plasma glucose test. • Diabetes self-management training.	Certain people with Medicare who are at risk for diabetes. Certain people with Medicare who are at risk for complications from diabetes. The beneficiary must be referred by their doctor.	Nothing for diabetes screening lab tests. For all other tests and services 20% of the Medicare-approved amount after the yearly Part B deductible. 20% of the Medicare-approved amount after the yearly Part B deductible.
Glaucoma Testing: • Once every 12 months. Must be done or supervised by an eye doctor who is legally allowed to do this service in the patient's state.	People with Medicare who are at high risk for glaucoma, including people with diabetes, a family history of glaucoma, or African Americans age 50 and older.	20% of the Medicare-approved amount after the yearly Part B deductible.

Medicare Part B Covered Preventive Services	Who is covered	What the patient pays in the *Original Medicare Plan*
Pap Smear and Pelvic Examination: (Includes a clinical breast exam) Once every 24 months. Once every 12 months if the beneficiary is at high risk for cervical or vaginal cancer, or if the beneficiary is of childbearing age and has had an abnormal Pap smear in the past 36 months..	All women with Medicare.	Nothing for the Pap lab test. For Pap test collection and pelvic and breast exams, 20% of the Medicare approved amount (or a co-payment amount) with no Part B deductible.
Prostate Cancer Screening: • Digital Rectal Examination - Once every 12 months. • Prostate Specific Antigen (PSA) Test - Once every 12 months.	All men with Medicare age 50 and older (coverage begins the day after the beneficiary's 50th birthday).	Generally, 20% of the Medicare approved amount for the digital rectal exam after the yearly Part B deductible. No coinsurance and no Part B deductible for the PSA Test.
Screening Mammograms: • Once every 12 months. (11 full months must have elapsed from the last screening.) • Medicare also covers new digital technologies for screening mammogram.	All women with Medicare age 40 and older. Patients can also get one baseline mammogram between ages of 35 and 39.	20% of the Medicare-approved amount with no Part B deductible.
Shots (vaccinations): Shots (vaccinations): • Flu Shot - Once a year in the fall or winter. • Pneumococcal Pneumonia Shot - One shot may be all you ever need. Patients should ask their doctor. • Hepatitis B Shot	All people with Medicare. All people with Medicare. Certain people with Medicare at medium to high risk for Hepatitis B.	Nothing for flu and pneumococcal pneumonia shots if the health care provider accepts assignment. For Hepatitis B shots, 20% of the Medicare-approved amount (or a co-payment amount) after the yearly Part B deductible.

Medicare Part B Covered Preventive Services	Who is covered	What the patient pays in the *Original Medicare Plan*
Welcome to Medicare Physical Examination: One time only, within the first six months the patient has Medicare Part B. Includes measurement of height, weight, and blood pressure, an EKG, education, and counseling	People whose Part B coverage began on or after January 1, 2005.	20% of the Medicare-approved amount after the yearly Part B deductible.

SECTION 10:

Key Definitions

Appeal An appeal is a special kind of complaint patients can make if they disagree with any decision about their health care service, for example, if Medicare doesn't pay for a service they got. This complaint is made to their Medicare health plan or the Original Medicare Plan. There is usually a special process they must use to make their complaint.

Assignment In the Original Medicare Plan, this means a doctor agrees to accept Medicare's fee as full payment. If patients are in the Original Medicare Plan, it can save them money if their doctor accepts assignment. They still pay their share of the cost of the doctor visit.

Benefit Period The way that Medicare measures a patient's use of hospital and skilled nursing facility services. A benefit period starts the day the patient goes to a hospital or skilled nursing facility. The benefit period ends when the patient hasn't received hospital or skilled nursing care for 60 days in a row. If they go into the hospital after one benefit period has ended, a new benefit period begins. They must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods patients can have.

Coinsurance The percent of the Medicare-approved amount that a patient has to pay after he or she pays the deductible for Part A and/or Part B. In the Original Medicare Plan, the coinsurance payment is a percentage of the cost of the service (e.g., 20%).

Coordination Period A period of time when a patient's employer group health plan will pay first on his or her health care bills and Medicare will pay second. If the patient's employer group health plan doesn't pay 100% of the patient's health care bills during the coordination period, Medicare may pay the remaining costs.

Deductible The amount a patient must pay for health care before Medicare begins to pay, either each benefit period for Part A, or each year for Part B. These amounts can change every year.

End-Stage Renal Disease (ESRD) Kidney failure that is severe enough to require lifetime dialysis or a kidney transplant.

General Enrollment Period (GEP) The GEP is January 1 through March 31 of each year. If a patient enrolls in Part B or Part A (if they don't get it automatically without paying a premium) during the GEP, their coverage starts on July 1.

Grievance A complaint about the way a patient's Medicare health plan is providing care. For example, a patient may file a grievance if he or she has a problem with the cleanliness of the health care facility, telephone access to the plan, staff behavior, or operating hours. A grievance is not the same as an appeal, which is the way to deal with a complaint about a treatment decision or a service that is not covered (see Appeal).

Medically Necessary Services or supplies that:

- Are proper and needed for the diagnosis or treatment of the patient's medical condition;
- Are provided for the diagnosis, direct care, and treatment of the patient's medical condition;
- Meet the standards of good medical practice in the medical community of the patient's local area; and
- Are not mainly for the **convenience of you, the patient's doctor.**

Medicare Advantage Plan A Medicare program that gives the beneficiary more choices among health plans. Everyone who has Medicare Parts A and B is eligible, except those who have End-Stage Renal Disease unless certain exceptions apply.

Medicare-Approved Amount This is the Medicare payment amount for an item or service. This is the amount the doctor or supplier is paid by Medicare and the patient for a service or supply. It may be less than the actual amount charged by the doctor or supplier. The approved amount is sometimes called the "Approved Charge."

Medicare Managed Care Plan These are health care choices in some areas of the country. In most plans, the beneficiary can only go to doctors, specialists, or hospitals on the plan's list. Plans must cover all Medicare Part A and Part B health care. Some plans cover extras, like extra days in a hospital. The beneficiary's costs may be lower than in the Original Medicare Plan.

Medicare Preferred Provider Organization (PPO Medicare Advantage Plan in which the beneficiary uses doctors, hospitals, and providers that belong to the network. The beneficiary can use doctors, hospitals, and providers outside of the network for an additional cost.

Medicare Private Fee-for-Service Plan A private insurance plan that accepts people with Medicare. The beneficiary may go to any Medicare-approved doctor or hospital that accepts the plan's payment. The insurance plan, rather than the Medicare program, decides how much it will pay and what the beneficiary will pay for the services they get. The beneficiary may pay more for Medicare-covered benefits. The beneficiary may have extra benefits the Original Medicare Plan does not cover.

Original Medicare Plan A fee-for-service health plan that lets the beneficiary go to any doctor, hospital, or other health care supplier who accepts Medicare and is accepting new Medicare patients. The beneficiary must pay the deductible. Medicare pays its share of the Medicare-approved amount, and the beneficiary pays their share (coinsurance). The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).

Premium What the beneficiary pays monthly for health care coverage to Medicare, an insurance company, or a health care plan.

Secondary Payer The insurance policy, plan, or program that pays second on a claim for medical care. This could be Medicare, Medicaid, or other insurance depending on the situation.

End Notes:

1. This overview of the MMA includes excerpts from the Health and Human Services Press Office News Release of Monday, December 8, 2003.
2. Calculation assumes 20 percent savings, on average, for the fully implemented benefit through a combination of management techniques (CMS Office of the Actuary).
3. In 2006, 150 percent of poverty would correspond to about $14,000 in annual income for a single individual and about $19,000 for a couple. 135 percent of poverty would be about $13,000 for singles and $17,000 for couples (Projection of 2003 Federal Poverty Levels).
4. A risk corridor is a financial risk sharing arrangement between the insurer and the government. If spending for the year is much higher than expected, the government will share the cost. However, the reverse is true. If spending for the year is much lower than expected, the government will share in the savings.
5. Covering Preventive Services Under Medicare: A Cost Analysis, Partnership for Prevention, 2003.

SECTION 11:

Index

U.S. Department of Health and Human Services
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Official Business
Penalty for Private Use, $300
Publication ICN # 006558
Revised May 2005